

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16253

State File No.

BIRTH NO.		REG. DIST. NO. <u>278</u>		PRIMARY REG. DIST. NO. <u>3955</u>		Registrar's No. <u>49</u>	
1. PLACE OF DEATH a. COUNTY <u>Pike</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Lansiana</u>		c. LENGTH OF STAY (in this place) <u>3 mos</u>		c. CITY OR TOWN <u>St. Johns 4 21/</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RJD #2</u>				STREET ADDRESS (If rural, give location) <u>8743 Egna Place</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u>		b. (Middle) <u>F.</u>		c. (Last) <u>SCOTT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 17, 1955</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>51</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool & Die Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air Plane</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Flat River Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>John</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>493-03-6657</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. VIOLA BEST - LOUISIANA, MO</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* a. <u>Cerebral Vascular Accident</u> INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis/Hypertension 10+ yrs</u> DUE TO (c) <u>Cardio-Vascular Disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <u>443 X</u> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 17</u> , 1955, to <u>May 17</u> , 1955, that I last saw the deceased alive on <u>May 17</u> , 1955, and that death occurred at <u>4:00 p</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Chas H. Lavelle M D</u>		23b. ADDRESS <u>Lansiana Mo</u>		23c. DATE SIGNED <u>May 18, 1955</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>5/18</u>		REGISTRAR'S SIGNATURE <u>Bernice Calhoun</u> 374		25. FUNERAL DIRECTOR'S SIGNATURE <u>Geo M Calhoun</u> <u>Lansiana Mo</u>		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 20 1956

FEB 8 1956

JUN 24 1956

JUL 22 1956

AUG 8 1956

SEP 14 1956

OCT 22 1956

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Geo. M. Callier*

Licensed Embalmer No. *283*

P. O. Address *Louisiana*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.